Commonwealth of Virginia
Health Benefits Program Application

This form shall be used by local employers to apply for coverage under The Local Choice Health Benefits Program sponsored by the Commonwealth of Virginia.

YOUR CURRENT HEALTH CARE COVERAGE SHOULD NOT BE TERMINATED UNTIL THIS APPLICATION AND AN ADOPTION AGREEMENT HAVE BEEN APPROVED AND ACCEPTED IN WRITING BY THE COMMONWEALTH OF VIRGINIA.

Today's Date: _____

I. GENERAL INFORMATION

1. Full name of local employer _____

_____

Type of group *(check both if applicable)*

☐ Local government ☐ School district ☐ Other (Please indicate): _____

2. Street Address _____

Mailing Address/P.O. Box _____

City _____ Zip Code _____

3. Plan administration executive correspondent *(This person will receive renewal and contractual information.)*

Name _____ Telephone Number _____

Title _____ Fax Number _____

E-mail Address _____

Address *(if different from above)* _____

_____

4. Group Benefits Administrator *(This is the person who should receive routine plan administration materials.)*

Name _____ Telephone Number _____

Title _____ Fax Number _____

E-mail Address _____

Address *(if different from above)* _____

_____

5. Has your group previously participated in The Local Choice Health Benefits Program? ☐ No ☐ Yes – From _____ to _____.
month/year *month/year*

6. **Applicable only for employers who offer no health care coverage to their employees** and whose employees elect to individually join the Health Benefits Program.

It is hereby certified that _____ (the Employer) offers no health care plan to employees. The Employer will, on behalf of employees who elect to individually join the Program, collect and remit premiums and assist the Department of Human Resource Management as necessary.

By: _____
(Name) *(Title)* *(Local Employer)*

(These Employers do not need to complete Section III.)

II. ELIGIBILITY REQUIREMENTS

1. Define permanent full-time employees to be eligible for coverage._____

_____

2. Are any permanent full-time employees to be excluded from eligibility? ☐ Yes ☐ No

If yes, please define: _____

_____

3. Are permanent part-time employees to be eligible? ☐ Yes ☐ No
   If yes, please define: _____

4. Are other employees to be eligible? ☐ Yes ☐ No
   If yes, please define: _____

5. Please describe any employees to be specifically excluded from coverage, in addition to those listed in question 2 of this section.

6. Please specify whether the information in questions 1-5 in this section differs in any way from the eligibility criteria for your current program. _____

7. Are retirees to be offered coverage? ☐ Yes ☐ No
   If yes, please explain terms and conditions including definition of retiree eligibility. _____

8. Please specify whether the information in question 7 in this section differs in any way from eligibility criteria for the current program.

9. Are dependents to be offered coverage? ☐ Yes ☐ No
   If yes, eligibility requirements will be outlined in benefits material.

10. Will employees be required to contribute to obtain employee coverage? ☐ Yes ☐ No
    If yes, please explain your current and future policy with regard to the amounts of employer and employee contributions:

11. Will employees be required to contribute to obtain dependent coverage? ☐ Yes ☐ No
    If yes, please explain your current and future policy with regard to the amounts of employer and retiree contributions:

12. Do you offer employees a choice of before or after-tax premium options? ☐ Yes ☐ No

13. Will retirees be required to contribute to obtain retiree coverage? ☐ Yes ☐ No
    If yes, please explain your current and future policy with regard to the amounts of employer and retiree contributions:

14. Will retirees be required to contribute to obtain dependent coverage? ☐ Yes ☐ No
    If yes, please explain your current and future policy with regard to the amounts of employer and retiree contributions:

15. Extended Coverage (COBRA) is not mandated for groups with fewer than 20 employees. However, The Local Choice allows you to offer Extended Coverage to your employees, regardless of size. Will you offer Extended Coverage to your employees? ☐ Yes ☐ No

16. Proposed effective date of participation: Month _____ Day _____ Year _____

17. Please indicate below the plans you intend to offer your employees:

Statewide Self Funded Plans:

Standard Package

☐ Key Advantage
☐ Key Advantage With Expanded Benefits
☐ Cost Alliance With Dental

Value Package

☐ KeyShare
☐ KeyShare With Expanded Benefits
☐ Value Alliance With Dental

Regional Fully Insured Plans:

☐ Health Maintenance Organization (HMO)
☐ Point Of Service (POS) Plan

III. FINANCIAL AND STATISTICAL INFORMATION

• Please Complete For All Current Insurance Plans Offered By Your Group:

1. Provide current insurance carrier(s), policy number(s), name and type of plan (HMO, PPO, POS, indemnity, etc):
   Name _____ Policy # _____ Type Plan _____
   Name _____ Policy # _____ Type Plan _____
   Name _____ Policy # _____ Type Plan _____

2. Provide a benefit plan booklet or certificate outlining the current medical plan, and note any recent changes for each of the plans maintained by your group.

3. Please attach current rates, renewal rates (if available) and "experience" analysis by the incumbent carrier(s) for the past three years.
   ☐ Information Attached

4. Please attach, if applicable, a full explanation of any special financial arrangements such as fully insured Administrative Services Only, holding reserve funds, Aggregate Stop Loss, deficit recovery agreements, Minimum Premium, etc. that are in effect.
   ☐ Information Attached

IV. PLAN DEMOGRAPHICS

1. Provide current census information of eligible employees/retirees for each benefit plan offered to include the following details. The chart on page 4 is available for this purpose.

   • Coverage category (active, retiree, COBRA, all other employees)
   • Employee identification number
   • Gender and date of birth
   • Type of membership (Employee Only, Employee and One Dependent, Family or waived status)
   • Job classification (regular full-time, regular part-time, temporary, etc.)

2. Please check the type of medical benefit plan maintained by your group.
   ☐ HMO ☐ PPO ☐ POS ☐ Indemnity

3. **NUMBER OF TOTAL ELIGIBLES** _____
   Number Of Active Employees _____ Number Of Retirees NOT Eligible for Medicare _____
   Number Of COBRA eligibles _____ Number Of Retirees Eligible for Medicare _____

4. Complete the charts to show the demographic make-up of your group.

ACTIVE COVERAGE

	Number Of Employee Only		Number Of Employee Plus One Dependent		Number Of Family	
Age Range	Male	Female	Male	Female	Male	Female
0-29						
30-39						
40-44						
45-49						
50-54						
55-59						
60-64						
Over 65						
Total						

RETIREE COVERAGE

	Number Of Retiree Only		Number Of Retiree Plus One Dependent		Number Of Retiree Plus Family	
Age Range	Male	Female	Male	Female	Male	Female
0-55						
56-59						
60-64						
65-69						
70-74						
75-79						
Over 80						
Total						

5. **Groups With Trigon Blue Cross Blue Shield Coverage Only:** I authorize the release of financial and statistical information from Trigon Blue Cross Blue Shield in order to establish rates for the benefit plans requested.

Signature _____ Title _____

IV. CERTIFICATION

I certify that the information supplied by me on this application is accurate to the best of my knowledge.

Signature _____

Application prepared by *(please print)* _____
(Name) *(Title)* *(Date)*

Telephone number (_____) _____ Fax number (if applicable) (_____) _____

E-mail Address _____

Forward completed Group Application to:

The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219
(804) 786-6460
E-mail: tlc@dhrm.state.va.us
Web: www.thelocalchoice@dhrm.state.va.us *(This form is available on the Web site.)*